***Enfield Youth Services***
***19 North Main Street***
***Enfield, CT 06082***
***(860)253-6380***

# *Release of Information*

**Consent for Authorization of Use/Disclosure of Protected Health Information**

CLIENT NAME_____ DOB_____
Adult ( ) Child ( )

Subject to the statement printed on this form, I, the undersigned client, hereby authorize Enfield Youth Services and its staff to use my medical, protected health information, case management, counseling, and, if applicable, protected drug and/or alcohol abuse, confidential HIV-related and psychiatric information for the purposes described below, and to ____obtain health information from or _____release and disclose health information to the following (list by name):

Name/Program: _____
Address: _____
City, State, Zip code _____
Phone: _____

The nature and extent of Protected Health Information to be obtained or disclosed: (*Check applicable information)*

( ) Intake Assessment
( ) Discharge Recommendation
( ) Psychiatric Evaluation
( ) Psychiatric Diagnosis only
( ) Psychological Evaluation/Testing
( ) Drug Abuse/Alcoholism Related Information
( ) Consultation Reports
( ) HIV Related Information
( ) Other

(Specify):_____

This authorization and any information released under it are to be used for the following purpose(s)

( ) Counseling
( ) Other (*please describe purpose for which the release is authorized, such as legal proceedings, medical care, behavioral health care, insurance, DCF investigations, school related concerns, etc.*

_____

**Please send information to the attention of: _____**

**Enfield Youth Services**
**19 N. Main Street**
**Enfield, CT 06082**
**FAX: 860-253-5145**

**Authorization of Use/Disclosure of Protected Health Information**
**Release of Information**

- I agree that a copy of this authorization will be as valid as the original. I understand that I may revoke this authorization at any time, except to the extent that information has already been released.

- This authorization will expire on _____; not to exceed a period of 120 days from the date of authorization below.

- I understand that under applicable federal and state law, the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

- I understand that my current or future counseling services provided by EYS is in no way conditional on whether or not I sign this authorization and that I may refuse to sign it.

This information to be obtained or disclosed was fully explained to me and this consent is given of my own free will.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian/Conservator/Legal representative Date

_____ _____
Witness Signature Date

**Any information released by EYS to authorized persons is subject to the following notices:**

**Psychiatric Information:** In the event that information released constitutes confidential, privileged psychiatric/client information protected under Connecticut law, Chapter 899, PL 93-579 of the Connecticut General Statutes: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to whom it pertains or as otherwise permitted by said law.

**Drug and Alcohol Abuse Information:** In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Client Records regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

**HIV-Related Information:** In the event that information released constitutes confidential HIV-related information protected under Connecticut law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient of this purpose.